

E-MAIL ADDRESS _____

Please Print LEGIBLY

Present Insurance Card and Driver's License to Receptionist

Patient

Name _____ Age _____ Date of Birth ____/____/____ SS# _____
Last First M.I.

Address _____ Apt# _____ City, State & Zip _____

Home# (____) _____ Work# (____) _____ Cell# (____) _____ Fax (____) _____

Marital Status (Circle one) Single Married Divorced Widowed

Occupation _____ Employer _____

Address _____

Spouse/Parent/Responsibility Party

Name _____
Last First M.I.

Address _____
Street City State Zip

Home# (____) _____ Work# (____) _____ Cell# (____) _____

Date of Birth _____ Sex _____ SS# _____

Employer & Address _____

Emergency Contact (*someone not in the house hold*)

Name _____
Last First MI

Address _____
Street City State Zip

Home # (____) _____ Work# (____) _____ Cell# (____) _____

Relation _____

How did you find out about our office? Phone Book Insurance Booklet Sign Other

(if a referral from which doctor?) Dr. Friend (please provide names) _____

INSURANCE INFORMATION

Copay/deductible amount \$ _____

Primary

Insurance Co Name _____ Phone# (____) _____

Claims Address _____

Group# or other # _____ Card Holder _____ Card Holder's DOB ____/____/____

ID/Subscriber# (other than SS#) _____ Card holder SS# _____

Secondary

Insurance Co Name _____ Phone# (____) _____

Claims Address _____

SS # _____ Group# or other # _____ Card Holder _____

Card Holder's DOB ____/____/____

Person Responsible for Bill _____
(if patient is a minor)

Address _____

Home Phone# (____) _____ Work Phone# (____) _____

Social Security # _____ Relationship _____

I understand that even though I may have some type of insurance coverage, I am fully responsible for full payment of all charges for services rendered to the above patient (or self). I understand I am financially responsible for all costs (legal/collection agency) in collecting my account if it is not paid within 90 days of service. **If I do not present valid insurance information at the time of service, I will pay for service when they are rendered** and I cannot request reimbursement of payment for retro-active coverage. I also understand that if my insurance claims are filed for me, it in no way relieves me of my responsibility of all bills. In the event that your account must be turned over to collections, a \$ 25.00 collection fee will be added to your account.

I authorize the release of medical information necessary to process all claims and also authorize payment of medical benefits to the physician and all insurance payments to be mailed directly to; 886 W. Foothill Blvd. #G, Upland, CA 91786. **Your signature below signifies your understanding and willingness to comply with this policy.**

Signed _____ Date ____/____/____

Dermatology Medical History

Patient: _____ Date of Birth ____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? Yes No Any bad reaction? Yes No

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast Infection when		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/ Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO If YES, _____

Has anyone in your family had skin cancer? YES NO If YES, _____

Do you have a history of any specific skin diseases? YES NO If YES, _____

Do you have problem with healing? YES NO

Do you have keloids (scars) after surgery? YES NO

Do you bleed easily? YES NO

Do you develop skin rashes in reaction to Medications Food Environment

Bandages Topical Neosporin Other _____

Social History

Do you drink alcohol? YES NO If YES _____ drinks per day

Do use IV drugs? YES NO If YES, what? _____ How often? _____

Do you smoke? YES NO If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the questions: **(Women) Are you pregnant?** YES NO Due date: ____/____/____

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ Signed by Patient _____ / / Date

Medical Assistant _____ Initials

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At the practice of Dr. Gloria Stevens and Dr. Ronald Liskanich, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your case.

We may use or disclose your health information for payment of your services. For example, we may send a copy of your chart to an insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

At this time we don't use an insurance billing service, but if we ever share your medical information with a business associate, we will have them sign a written contract that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters, recall cards; we may notify you of laboratory and pathology results. We may also want to call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine or with the person that answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509f, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGMENT

I have received a copy of the Dr. Gloria Stevens/Dr. Ronald Liskanich Notice of Privacy Practices.

Signed _____ Print Name _____ Date: _____

Please write names of all family members that are patients in this office:

How were you referred to our office?
(Please check one of the following)

- Doctor _____
- Another Patient _____
- Insurance Company
- Clark Yellow Book (Small Book)
- Verizon Yellow Pages (Large Book)
- Internet Yellow Pages
 - Super Pages
 - AT&T Yellow Pages
 - Yahoo Yellow Pages
 - Other _____
- Internet Search Engine
 - Google
 - Yahoo
 - MSN
 - AOL
 - Other _____
- Inland Empire Magazine
- Office Sign
- Other _____

Name _____

Patient's E-mail address: _____
(for special promotions and quarterly newsletters)